

Chiropractic services

Table of costs and guidelines
Effective from 1 July 2009

[View table of costs only](#)

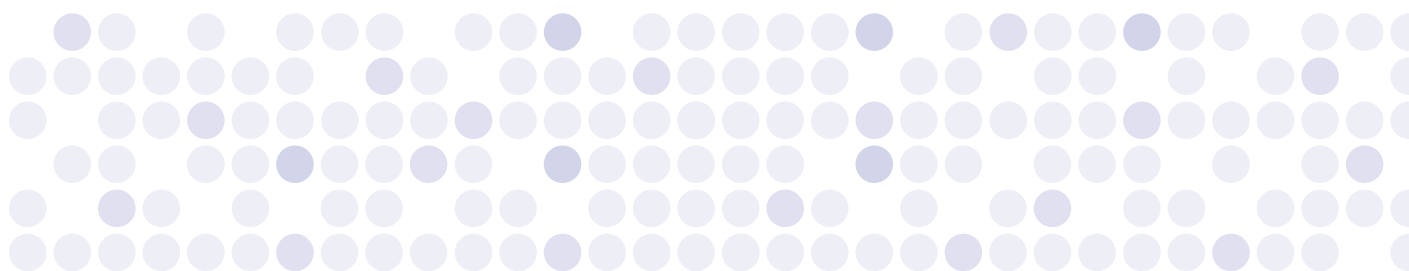


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Section A

1. Introduction

This document outlines the general standards and expectations, procedures and conditions for delivering chiropractic services to workers. It also explains and clarifies the use of specific item codes. This information should assist the treating medical practitioner, the employer, the insurer, and you, the chiropractor, by promoting quality service provision and timely, relevant rehabilitation information.

In the majority of cases, the rehabilitation goal is for the worker to return to work. In situations where the injury prevents the worker returning to work, rehabilitation must focus on maximising functional independence.

1.1 Who is qualified to deliver chiropractic services?

Only a person registered as a chiropractor with the Queensland Registration Board is qualified to deliver chiropractic services to workers in Queensland. For services provided to workers outside Queensland, the treating chiropractor must be eligible for registration in Queensland.

2. Procedures and conditions

Payment for services outlined in this document is subject to the following procedures and conditions.

2.1 Referral

The worker may only be referred by a registered medical practitioner and must have a **current** medical certificate to cover any chiropractic services provided.

Insurers will not pay for general communication such as receiving and reviewing referrals.

2.2 Assessment

You are expected to assess the needs of the worker in the initial consultation session and then notify the referrer of the outcome of the assessment and future treatment goals.

You **may not** invoice for both an initial and subsequent consultation on the same day without **prior** approval from the insurer.

2.3 Treatment approval

For an accepted claim, the insurer will pay the cost of an initial consultation and report when it has been requested by the treating medical practitioner or an accredited workplace/employer or insurer.

Where the claim has been accepted, the insurer will pay for a maximum of **seven (7)** chiropractic sessions **without prior approval**.

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For any service requiring **prior approval** from the insurer, you must submit a *Provider management plan* and obtain approval before treatment commences (see the *Allied health provider form guidelines*).

For services not outlined in this *Table of costs and guidelines*, you must obtain **prior approval** from the insurer by submitting a *Provider management plan* (see the *Allied health provider form guidelines*).

Where you are required to submit a *Provider management plan*, the insurer will advise you of their decision about approval of the plan as soon as possible. The insurer **will not pay** for any services provided **without prior approval**.

The insurer will not pay you for preparing or completing the *Provider management plan*.

2.3.1 Allowable treatment period

The insurer will pay for a maximum of **seven (7)** chiropractic sessions **without prior approval**.

The seven (7) sessions may be a combination of various services—for example in-rooms treatment, hospital consultation. This excludes those services where prior approval is required.

The insurer **will not pay** for more than seven (7) sessions unless you have obtained prior approval by submitting a *Provider management plan* (see the *Allied health provider form guidelines*)

The initial seven (7) pre-approved sessions may not be undertaken concurrently with sessions requiring the insurer's prior approval.

2.4 Treatment

2.4.1 General standards and expectations

When treating a worker with a compensable injury, you should, where appropriate:

- liaise with relevant parties involved in managing the claim to coordinate medical treatment for the worker, promoting an early and safe return to work
- advise and liaise with the relevant treating practitioners and insurer at the start of a treatment program for each new claim or re-opening of a claim where it is in the best interest of the worker's ongoing management
- regularly review and document the worker's treatment progress in case notes
- ensure that the worker has given their written authority prior to the exchange of information with third parties other than the referrer
- deliver outcome-focused and goal-orientated services, which are focused on achieving maximum function and safely returning the worker to work
- be accountable for the services provided, ensuring those services incurred for the compensable injury are reasonable
- maintain practice competencies relevant to chiropractors and the delivery of services within the Queensland workers' compensation environment. This

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includes maintaining currency of skills and knowledge of specific chiropractic modalities

- keep detailed, appropriate, up-to-date treatment records and any relevant information obtained in the service delivery.

Note: long-term maintenance therapy is generally not supported unless sustained improvement in function can be demonstrated.

2.4.2 Treatment period

When a worker returns to work (including suitable duties) and needs more chiropractic treatment, the treatment will be considered as continuing and the seven (7) session rule applies.

In all cases, treatment will be deemed to have ended if there is no treatment for a period of **two (2) calendar months**. You need to conduct a new initial consultation and submit a *Provider management plan* for approval of any subsequent treatment. In this situation, the worker must obtain another referral from a registered medical practitioner.

All insurer payments for treatment end when there is no further medical certification or the insurer finalises/ceases the claim.

2.4.3 Postoperative chiropractic treatment

When a worker is referred for chiropractic treatment after a surgical procedure, a new set of seven (7) treatments will take effect.

2.4.4 Change of provider

When a worker changes chiropractors from one to another—not within the same practice—the insurer will pay the cost of an initial consultation by the new chiropractor to:

- determine the number of sessions already provided
- allow for an assessment and appropriate treatment
- submit a *Provider management plan*.

You are responsible for determining if the worker has received previous chiropractic treatment, including when and how many sessions, so that a *Provider management plan* can be submitted.

2.5 Provider management plans

For details of when and how to use the *Provider management plan*, see the *Allied health provider form guidelines*.

Obtain the *Provider management plan* and *Allied health provider form guidelines* from Q-COMP's website at www.qcomp.com.au or call 1300 789 881.

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3. Indicators for ending treatment/intervention

There are a number of indicators highlighting that treatment is no longer needed or should be stopped. These include:

- the outcome and goals are achieved
- the presenting condition has been resolved
- the worker is not complying and there is lack of progress (you must discuss this with the insurer)
- the worker has achieved maximum function of the injured area, meaning progress has reached a plateau.

4. Payment for services

Payment for services outlined in this document is allowed subject to the relevant conditions of service outlined in section B for the relevant item number.

The worker's compensation claim must have been accepted by the insurer for the injury or condition being treated.

If the application for compensation is pending or has been rejected, the responsibility for payment for any services provided during any period remains a matter between you and the worker or the employer (where services have been requested by the Rehabilitation and Return to Work Coordinator).

Send all invoices to the relevant insurer for payment—check whether the worker is employed by a self-insured employer or an employer insured by WorkCover Queensland. For a current list of insurers visit Q-COMP's website at www.qcomp.com.au or call Q-COMP on 1300 789 881.

Identify the appropriate item in this *Table of costs and guidelines* for services or treatment provided. The insurer will only consider payment for services or treatments for the compensable injury, not other pre-existing conditions.

4.1 Provider invoice

Insurers will pay for services in accordance with this *Table of costs and guidelines*. To ensure payment, your invoice must contain the following information:

- the words 'Tax Invoice' stated prominently
- your name and practice details
- tax invoice issue date
- your Australian Business Number (ABN)
- worker's name, residential address and date of birth
- worker's claim number (if known)
- referring medical practitioner's name
- date of each attendance
- appropriate table of costs item number/s
- a brief description of each service item supplied, including areas treated
- treatment cost
- name of your staff member who provided the service.

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Fees listed in this table of cost and guidelines **do not include** GST. You are responsible for incorporating any applicable GST on taxable supplies into your invoice. Refer to a taxation advisor or the Australian Taxation Office for help on the taxability of certain services.

Self-insurers require **separate tax invoices** for services to individual workers. The self-insurer will return an invoice to you where the services are for more than one injured worker. For a current list of self-insurers, visit Q-COMP's website at www.qcomp.com.au.

WorkCover Queensland will accept billing for more than one worker on a single invoice.

5. Inquiries

5.1 Claims issues

Contact the appropriate insurer for claims issues, including:

- payment of invoices and account inquiries
- claim numbers
- claim status
- rehabilitation status
- approval of *Provider management plans*.

For a current list of insurers, visit Q-COMP's website at www.qcomp.com.au or call Q-COMP on 1300 789 881.

5.2 General inquiries

For advice about the tables of costs and guidelines, call Q-COMP on 1300 789 881.

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Section B

6. Service type (service codes)

The following service items are for chiropractic services provided within the provider's rooms or a hospital.

Before providing services to workers, you are responsible for ensuring that you understand the service conditions and objectives of this table of costs.

6.1 Initial consultation (500021 & 500313)

Item Number	Descriptor
500021	Initial consultation Initial chiropractic consultation, including activities outlined below.
500313	Initial consultation (multiple area) Where two (2) or more entirely separate injuries or conditions are assessed and treated and where treatment applied to one condition does not affect the symptoms of the other injury—for example a neck condition and lumbar spine fracture. This does not include a condition with referred pain to another area. Consultations billed under this item number are for multiple clinical conditions/areas. The insurer may pay for the consultation if it relates to the compensable injury and there is a medical certificate detailing each area or condition to be treated.

Service conditions

Prior approval required from the insurer – No

An initial consultation by a chiropractor may include all or some of the following elements.

Subjective (history) reporting – consider major symptoms and lifestyle dysfunction; current history and treatment; past history and treatment; pain, aggravating and relieving factors; general health; medication; risk factors and key functional requirements of the worker's job.

Objective (physical) assessment – assess movement—for example active, passive, resisted, repeated, muscle tone, spasm, weakness, accessory movements, passive intervertebral movements—and pain by carrying out appropriate procedures and tests.

Assessment results (prognosis formulation) – provide a provisional prognosis for treatment, limitations to function.

Treatment (intervention) – provide treatment during the initial consultation at your discretion. Discuss working hypotheses, treatment goals and expected outcomes;

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initial treatment and expected response with the worker. Advise on home care, including any exercise programs to be followed.

Clinical records – record information in the worker’s clinical records, including the purpose and results of procedures and tests.

Communication (with the referrer) – communicate any relevant information for the worker’s rehabilitation to insurer. Acknowledge referral and liaise with the treating medical practitioner about treatment.

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6.2 Subsequent consultation (500108, 500006, 500101 & 500102)

Item Number	Descriptor
500108	<p>Subsequent consultation level A Involves selective review of a treatment program where a standard consultation (level B) is not required. This may include a brief or partial reassessment and clinical record components as described below or where you may be seeing multiple clients and treatment is not strictly one-on-one.</p>
500006	<p>Subsequent consultation level B (standard consultation) Management of one area/condition only. See below for elements required in the consultation.</p>
500101	<p>Subsequent consultation level C Where two (2) entirely separate injuries or conditions are assessed and treated and where treatment applied to one condition does not affect the symptoms of the other injury—for example a neck condition plus post fracture wrist or treatment of a knee and ankle. It does not include a condition with referred pain to another area. See below for elements required in the consultation.</p> <p>Note: Consultations billed under this item number are for multiple clinical conditions/areas. The insurer may pay for the consultation if it relates to the compensable injury and there is a medical certificate detailing each area or condition to be treated.</p>
500102	<p>Subsequent consultation level D Where more than two (2) entirely separate injuries or conditions are assessed and treated and treatment applied to one condition does not affect the symptoms of the others. This is most likely to occur after a vehicle accident where there are multiple injuries. It does not include a condition with referred pain to another area. See below for elements required in the consultation.</p> <p>Note: Consultations billed under this item number are for multiple clinical conditions/areas. The insurer may pay for the consultation if it relates to the compensable injury and there is a medical certificate detailing each area or condition to be treated.</p>

Service conditions

Prior approval required from the insurer –The first seven (7) sessions—including the initial—are pre-approved. Additional sessions require prior approval.

Treatment conditions

The *Workers' Compensation and Rehabilitation Act 2003*, section 211 states '*The insurer's liability for the cost of medical treatment by a registered chiropractor...extends*

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only to the costs of treatment involving the manipulation, mobilisation and management of neuromusculoskeletal systems of the human body’.

A subsequent consultation by a chiropractor may include all or some of the following elements.

Treatment (intervention) – provide treatment modalities and/or therapeutic exercises according to the goals of therapy. May include appropriate home program modifications in line with progress or otherwise identified from reassessment. This includes feedback to the worker on their progress or otherwise and expected outcomes of the plan.

Clinical records – record information in the worker’s clinical records, including the purpose and results of procedures and tests.

Communication – discuss any relevant factors impeding progress with the worker’s treating medical practitioner and/or insurer as soon as possible. Does not include extended communication—for example case conferencing which has a specific item number (see the *Supplementary services table of costs and guidelines*).

Reassessment (subjective and objective) – evaluate the physical progress of the worker using outcome measures for relevant, reliable and sensitive assessment. Compare against the baseline measures and treatment goals. Identify factors compromising treatment outcomes.

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6.3 Re-assessment/program review (500055)

Item Number	Descriptor
500055	<p>Re-assessment/program review is indicated when:</p> <ul style="list-style-type: none">• the worker has been in active rehabilitation for six (6) weeks, further treatment is likely and the insurer agrees that reassessment is required• there are new clinical findings that might affect treatment• there is a rapid change in the worker's status• there is no response to therapeutic interventions.

Service conditions

Prior approval required from the insurer – Yes

Re-assessment/program review – a more comprehensive assessment including all the components of the initial consultation—refer to initial consultation item (500021 or 500313) descriptor for further guidance. You should review the worker's progress based on established objective measures since the initial assessment and recommend effective future treatment and management strategies to assist the worker to return to work. This may include:

- recommendations for referral to other professional disciplines
- change in therapy direction
- change in outcome direction requiring a new return to work goal.

You should submit your findings to the insurer for approval using a *Reassessment/program review provider management plan*, which includes:

- an assessment of the worker's progress against the outcome measures established during the initial consultation and monitored throughout the treatment period to date. Highlight meaningful changes in function and remaining functional gaps to be addressed (where did you start, where are you now, where are you going?)
- objective measurements based on appropriate and relevant assessment using comparable and consistent methods
- a clinical judgment as to whether intervention/s are effective and if continued treatment is still warranted
- barriers and strategies to overcome issues identified with the worker's ability to return function.

When is a reassessment/program review not required?

Reassessment/program reviews are not required:

- during routine reassessments as part of each treatment session
- where the worker is already on a clear management plan and is progressing as expected
- following postoperative protocols
- where a rehabilitation program extends beyond the reassessment period
- where the treating medical practitioner assesses the worker and recommends continued or more specific treatment.

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6.4 X-rays (558100, 558103, 558106, 558112 & 558115)

Item Number	Descriptor
Radiographic imaging is an integral part of the procedures offered by a chiropractor, either in a chiropractic clinic or through referral.	
558100	Cervical spine
558103	Thoracic spine
558106	Lumbosacral spine
558112	Any two (2) regions of the spine
558115	Any three (3) regions of the spine

Service conditions

Prior approval required from the insurer – No (must be clinically justifiable).

Service objectives

Chiropractors use radiography for several purposes, including:

- confirmation of pathology
- appropriateness for care
- identifying contraindications or modifying factors affecting the selection of appropriate management and adjustment of technique
- practitioner confidence to proceed
- the need to allay high patient anxiety/fear.

Indicator for use

Indications for x-ray must be clear and based upon clinical history and examination findings where the results of such imaging will assist in the, prognosis and management of the patient and where the potential benefit outweighs the risks of ionising radiation. A patient should never be exposed to unnecessary radiation.

Current research literature emphasises the need for x-rays in cases where 'red flags' (suspected pathology) are obtained from the clinical history and examination—for example:

- progressive neurological signs and symptoms
- suspected tumour/pathology
- infection
- age greater than 50 years
- trauma.

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Consent

You must discuss the need for, and the nature of, the recommended x-rays with your patient, and obtain their written consent. In the case of minors or the mentally incompetent, you must obtain consent from a parent or legal guardian.

Children

Workers under 18 years old generally have low justification for x-rays due to the high sensitivity of many body tissues. Exceptions include defects producing aberrant spinal curvatures, marked locomotor disturbances of the spine and pelvis, suspicion of pathology or significant trauma.

Contraindications

Routine x-ray screening of patients and the routine re-evaluation of biomechanical/postural disorders, other than for exceptional circumstance, is inappropriate.

Serial or follow-up x-rays are not indicated if the patient is making adequate clinical recovery. Exceptions include progressive pathology and fracture repair. If the patient's response is inadequate or adverse, then a full re-evaluation is warranted, with the possibility of further investigation and/or referral.

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6.5 Other - Independent case review (500226)

Item Number	Descriptor
500226	<p>Independent case review – includes assessment and report Where progress of treatment and/or rehabilitation falls outside the plan or expected course of injury management, the insurer may request an examination and report of a worker by an independent case reviewer (not the treating chiropractor) to provide the insurer with an assessment and recommendations for ongoing treatment and prognosis.</p> <p>This service includes assessment and report.</p>

Service conditions

Prior approval required from the insurer – Yes. Only to be provided following a request from the insurer.

Service objectives

The purpose of an independent clinical assessment is to:

- assess and make recommendations about the appropriateness and necessity of current or proposed chiropractic treatment
- propose a recommended course of chiropractic management
- make recommendations for strategic planning to progress the case.
Recommendations should relate to treatment goals and steps to achieve those goals, which will assist in a safe and durable return to work
- provide a professional opinion on the worker's prognosis where this is unclear from the current chiropractic program
- provide an opinion and/or recommendation on the other criteria as determined by the requestor.

Note: this may also require communication with the current treating provider.

This service includes assessment and report.

Chiropractic services table of costs

Effective 1 July 2009
For use by a registered chiropractor

Important note – the worker must always be referred by a registered medical practitioner and have a current medical certificate to cover any services provided.

Service	Descriptor	Insurer prior approval required ¹	Item number ²	Fee GST excluded [#]
Initial consultation				
Initial consultation	First consultation with worker.	No	500021	\$66.99
Initial consultation (multiple area)	Two or more entirely separate injuries/conditions assessed and treated; treatment applied to one condition does not affect the symptoms of the other injury; must relate to the compensable injury ; requires medical certificate detailing each area/condition to be treated.	No	500313	\$100.58
Subsequent consultation				
Subsequent consultation – level A	Selective review of treatment or exercise program where a standard consultation (level B) is not required; may include brief or partial reassessment.	The first seven sessions (including initial consultation) are pre-approved. Additional session/s require prior approval.	500108	\$41.69
Subsequent consultation – level B	Standard treatment consultation—management of one area only.		500006	\$56.18
Subsequent consultation – level C	Two entirely separate injuries or conditions are assessed and treated; treatment applied to one condition does not affect the symptoms of the other injury; does not include a condition with referred pain to another area.		500101	\$80.92
Subsequent consultation – level D	More than two entirely separate injuries or conditions are assessed and treated; treatment applied to one condition does not affect the symptoms of the others; does not include a condition with referred pain to another area.		500102	\$107.95

¹ Where prior approval is indicated you must seek approval from the insurer before providing services.

² Before billing for services please read the *Chiropractic services table of costs and guidelines* available from Q-COMP's website at www.qcomp.com.au.

[#]Rates do not include GST. If GST is required it is up to the provider to include it in the invoice. For clarification regarding GST contact the Australian Taxation Office.

Chiropractic services table of costs

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For use by a registered chiropractor

Service	Descriptor	Insurer prior approval required ¹	Item number ²	Fee GST excluded [#]
Reassessment/program review				
Reassessment/program review	Indicated when the worker has been in active rehabilitation for six weeks and further treatment is likely.	Yes	500055	\$77.79
X-ray				
	Cervical spine.	No (must be clinically justifiable).	558100	\$147.87
	Thoracic spine.		558103	\$122.30
	Lumbosacral spine.		558106	\$171.22
	Any two regions of the spine.		558112	\$215.69
	Any three regions of the spine.		558115	\$295.74
Other				
Independent case review	Independent examination and report of a worker—not by the treating therapist, includes assessment and report.	To be provided only following a request from the insurer.	500226	\$186.21 per hour

For details of when and how to use a *Provider management plan* see the *Allied health provider form guidelines* – both available from Q-COMP's website at www.qcomp.com.au or call Q-COMP on 1300 789 881.

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